Phone: 623-251-5518 Fax: 623-249-4748

PATIENT IN	FORMATION	1						
Patient Name SS# Address			Date of	Birth		Date:		Sex M F
E-Mail Married Occupation Partner's Nan	Widowed	Single Minor	Separated	Divorced	Partnered for Employer/School	_ years		
	e thank for ref	erring you?						
PHONE NUM	BERS							
Home			Cell _			Work		
Best time and place to reach you:  I give permission for my doctor or staff to leave a message on my home telephone or cellular phone.  Yes No  I give permission to speak on matters regarding my healthcare to:								
IN CASE OF	EMERGEN	CY CONTACT						
Name				Relatio	nship			
Home				Work				
INSURANCE								
					abs that may be reco ard and photo ID so			our chart.
Who is responsible for this account if different from patient?  Relationship to patient:  Insured's date of birth if different from patient:  Insured's phone if different from patient:								
Insured's address if different from patient:  If you have more than one insurance plan please list primary and secondary insurance:								
Primary Insur	ance:							
Secondary Ins	surance:							
INSURANCI I certify that I								
Name of Insurance Company (ies)  And assign directly to Dr. Jennifer Gentry all insurance benefits, if any, otherwise payable to me for service rendered. I understand I am financially responsible for all charges up front whether or not paid by my insurance. Dr. Jennifer Gentry will reimburse to me any payments my insurance company authorizes once a check is received by her office. I authorize the use of my signature on all insurance submissions.  Dr. Jennifer Gentry may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services for my reimbursement and determining insurance benefits or the benefits for related services. The consent will end when my current treatment plan is completed.								
Signature of Insured, Guardian, or Personal Representative								
Please Print N	lame of Insure	d, Guardian, or Per	sonal Represe	ntative	Date	Relatio	onship to Insu	ired
FAMILY HIST	OPV							
What is your re		lay's visit						
ALIVE DECEASED	FATHER	Present health or ca	nuse of death	MOTHER	Present health or cat	use of death S	SPOUSE P	resent health or cause of death
SIBLINGS	# ALIVE	# DECEASED	Present heal	th or cause of de	ath:			
Family Illness:	Diabetes C	ancer : TYPE:		Bleedi	ng tendency Kidne	y disease Tube	erculosis A	coholism/Drug Use

Heart disease Stroke High Blood Pressure Nervous Illness Allergy: TYPE: \_\_\_\_\_\_ Other: \_\_\_\_\_

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Patient Name Today's Date

Pharmacy Name \_

Phone

Patient Name Today's Date						
HEALTH HISTORY/SYMPTOMS						
Check all conditions you have or have had in the PAST 3 MONTHS						
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY			
□ Chills	<ul><li>Poor appetite</li></ul>	Bleeding gums	□ Breast lump			
□ Depression	Bloating	Crossed eyes	Erection difficulties			
□ Dizziness	<ul><li>Bowel changes</li></ul>	<ul><li>Difficulty swallowing</li></ul>	Lump or pain in testicles			
□ Fainting	<ul><li>Constipation</li></ul>	Double vision	Penis discharge			
□ Fatigue	<ul><li>Diarrhea</li></ul>	Ear ache	☐ Sore on penis			
□ Fever	<ul><li>Excessive hunger</li></ul>	<ul><li>Ear discharge</li></ul>	□ Other			
□ Forgetfulness	Excessive thirst	Hay fever	Last PSA:			
☐ Headache	□ Gas	<ul><li>Hoarseness</li></ul>	WOMEN ONLY			
Intolerant to exercise	<ul><li>Hemorrhoids</li></ul>	<ul><li>Loss of hearing</li></ul>	□ Abnormal pap smear			
Irritable/Shaky when hungry	Indigestion	<ul><li>Nasal congestion</li></ul>	☐ Bleeding between periods			
□ Loss of sleep	■ Nausea	Nose bleeds	☐ Breast lump			
Loss of weight	<ul><li>Rectal bleeding</li></ul>	<ul><li>Ringing in ears</li></ul>	☐ Breast tenderness			
□ Nervousness	<ul><li>Stomach pain</li></ul>	<ul><li>Sinus problems</li></ul>	□ Decreased libido			
□ Numbness	<ul><li>Vomiting</li></ul>	Vision - blurry	☐ Extreme menstrual pain			
□ Salt Cravings	Vomiting blood	Vision - night blindness	☐ Hot flashes			
Sensitive to fumes/chemicals	Other:	Vision - flashes	☐ Irregular menses			
☐ Stool changes		Vision - halos	☐ Miscarriages/Total:			
□ Sweats	CARDIOVASCULAR	Vision - light sensitivity	☐ Nipple discharge			
MUSCLE/JOINT BONE	Chest pain	SKIN/HAIR/NAILS	□ Osteoporosis			
Pain, weakness or numbness in	<ul><li>Heart palpitations</li></ul>	□ Acne	□ Painful Intercourse			
	High blood pressure	☐ Bruise easily	☐ Vaginal discharge			
•	<ul><li>Irregular heart beat</li></ul>	☐ Discoloration of skin	☐ Vaginal dryness			
☐ Back ☐ Legs ☐ Feet ☐ Neck	<ul><li>Low blood pressure</li></ul>	☐ Hair loss	a vaginararyness			
☐ Hands ☐ Shoulders	<ul><li>Poor circulation</li></ul>	☐ Hair excess	Date of last period:			
	<ul><li>Rapid heart beat</li></ul>	☐ Hives	-			
GENITOURINARY	□ Swollen ankles	☐ Itching	Date of last pap smear:			
☐ Blood in urine	□ Water retention	☐ Change in moles	Date of last mammogram:  Date of last bone density:			
☐ Color change in urine	<ul><li>Varicose veins</li></ul>	□ Rash				
□ Frequent urination	D. II 440.14 D. V	☐ Scars/Stretch marks	Date of last colonoscopy:  Number of children and year			
□ Lack of bladder control	PULMONARY	☐ Sore that won't heal	Number of children and year			
□ Painful urination	□ Persistent cough	☐ Weak/Brittle nails/Hair				
	<ul><li>Spitting up blood or phlegm</li></ul>					
		<b>DITIONS</b> or have had. NOTE THE YEAR.				
☐ AIDS/ HIV Positive	□ Chemical dependency	☐ Hypoglycemia	☐ Prostate problem			
□ Alcoholism	☐ Chicken Pox	□ Infertility	☐ Psychiatric care			
□ Anemia	<ul><li>Diabetes</li></ul>	Kidney disease/Stones	□ Rheumatic fever			
□ Anorexia	<ul><li>Emphysema</li></ul>	Liver disease	□ Scarlet fever			
Appendicitis	□ Epilepsy	Measles	□ Stroke			
□ Arthritis	<ul> <li>Gallbladder disease</li> </ul>	Migraines	Suicide attempt			
□ Asthma	□ Glaucoma	Miscarriage	Thyroid problem			
Bladder infections	□ Goiter	Mononucleosis	□ Tonsillitis			
Bleeding disorders	☐ Gout	<ul><li>Multiple Sclerosis</li></ul>	□ Tuberculosis			
□ Breast lump	<ul><li>Heart disease</li></ul>	Mumps	Typhoid fever			
□ Bronchitis	<ul><li>Hepatitis</li></ul>	<ul><li>Ovarian cysts</li></ul>	□ Ulcer			
□ Bulimia	<ul><li>Hernia</li></ul>	<ul><li>Pacemaker</li></ul>	Vaginal infection			
□ Cancer	□ Herpes	□ Pneumonia	□ Venereal disease			
□ Cataracts	☐ High cholesterol	□ Polio	☐ Other:			
MEDICATIONS AI	ND SUPPLEMENTS	AL	LERGIES			
	ently using and the DOSE		oods or Other and EFFECT			
		1				
		1				

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Have you had any surgeries or hospitalizations (Please include date, condition treated, and adverse events/outcome of the procedure).					
Please list any significant life event that you feel has affected your health and the date:					
What is your current level of commitment to addressing these issues? (Please choose the one that best fits.)  I am willing to make <b>ANY</b> changes and do whatever is necessary.  I am willing to make <b>SOME</b> changes in my lifestyle to feel better.  I am specifically looking for a medical/surgical alternative but <b>do not want to change</b> my lifestyle.  I am here to learn more about my healthcare options and what you offer.  Other:					
What spiritual or religious activities do you have if any?					
What type of exercise and frequency of exercise do you prefer?					
What occupation do you currently have?					
What previous occupations have you had?					
What hobbies do you have? (chemical or metal exposures)					
Have you lived in industrial or agricultural areas? (pollution)					
What would you rate your daily stress level? (0-10, 10 highest) For how many years?					
How do you feel on waking in the morning?					
How do you feel at night before bed?					
How many hours of sleep do you get per night during the week? Is it interrupted?					
Have you had all childhood vaccinations? When was your last tetanus vaccine?  Have you ever had a bad reaction to a vaccination? What reaction and to which vaccine.					
Do you smoke? Yes No How often? How many years? How many packs per day?					
What motivates you to smoke?  Do you want to quit? Yes No					
Do you use recreational drugs? Yes No Type and with what frequency?  Do you consume alcohol, what type and what amount/frequency?					
Do you experience gas, bloating or indigestion with any particular food, if so what food(s)?  Is there undigested food, mucus, or blood in your stools?					
How frequently do you drink (per day/week) of the following (Daily and how many glasses, weekly, occasionally, never) Juice? Soda? Energy Drinks? Coffee? Water? Are you following a special diet or do you have any food restrictions? (eg. dairy free, gluten free, Paleo, Adkins, I won't eat vegetables etc.)					
If your condition is chronic (you have looked for answers for years without results), what do you think is the cause of your illness and what treatments have you tried successfully or unsuccessfully?					
Is there anything else you would like the doctor to know which may help him/her to better understand your healthcare?					

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### PATIENT AFFIRMATION OF CONTRACTS

Regarding the Health Services, Notice of Privacy Practices, & Consent to Treat Contracts
All contracts are available to read in our office and on our website: www.DrJenGentry.com

#### **HEALTH SERVICES CONTRACT**

I have read the "Health Care Services Contract." I have read and understand my patient rights and the financial policies of Calvo Naturopathic and agree to the terms and conditions. I understand that there is a fee for missed appointments and for lengthy phone consults. Fees at Calvo Naturopathic may change, but I will always be made aware of any changes prior to my visit. Calvo Naturopathic will provide a copy of the "Health Care Services Contract" to me at my request or I may access this information at <a href="https://www.DrJenGentry.com">www.DrJenGentry.com</a>

#### NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided information on how my personal health information may be used in accordance with HIPAA federal regulations. I have read, or have had read to me the "Notice of Privacy Practices" and agree to the terms and conditions. Calvo Naturopathic will provide a copy of the "Notice of Privacy Practices" to me at my request or I may access this information at <a href="https://www.DrJenGentry.com">www.DrJenGentry.com</a>

### CONSENT TO TREAT CONTRACT

I am seeking medical health care services at Calvo Naturopathic. I have read, or have had read to me the "Consent to Treat Contract" and agree to the terms and conditions. I will always have an opportunity to discuss the value of any treatment and will have an opportunity to verbally agree to a treatment before it is performed. If I refuse a particular therapy, this will be noted in my chart for future reference. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Calvo Naturopathic will provide a copy of the "Consent to Treat Contract" to me at my request or I may access this information at <a href="https://www.DrJenGentry.com">www.DrJenGentry.com</a>.

### RELEASE OF INFORMATION

I give the physician the authority to share with any consultant all information deemed necessary to coordinate my medical care. This includes sharing/mailing/faxing information such as office notes, EKGs, laboratory results, x-ray reports, medication lists and other consultant's notes to physicians, hospitals, pharmacists and insurance companies.

## **INSURANCE AND ASSIGNMENT OF BENEFITS**

Calvo Naturopathic is not an insurance provider. Super bills are gladly provided and insurance is filed on request; however, reimbursement is not guaranteed. Medicare does not cover naturopathic care. I understand I am always responsible for pre-payment regardless of the insurance coverage I may have.

I assign any insurance benefits to which I may be entitled to the physician providing the services. These benefits will be reimbursed to me if there is a credit on my account. I understand that I am responsible for any charges not covered by this assignment. I authorize release of any medical or other information necessary to process my insurance claims. I authorize the physician to provide from my records any and all information requested by my insurance company or other third party payer, in connection with payment for my incurred charges. I also authorize the physician to provide any quality review organization affiliated with my insurer the information it requests for use in Utilization Management/Review. Some plans may require a referral from my primary care physician and it is my responsibility. I authorize disclosure of records to my insurance carrier, lawyer, or referring practitioner.

#### **EMERGENCIES**

I understand that if I have an urgent medical condition, and am unable to reach Dr. Gentry, it is my responsibility to seek appropriate medical care. I understand that IF THERE IS A MEDIAL EMERGENCY I AM TO DIAL 911 IMMEDIATELY.

Date:	
Patient Name (Printed):	
Parent or Legal Guardian if applicable (Printed):	
Patient Signature (or Parent or Legal Guardian):	

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### PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:	Jernife ( Genery, N)		By:		
	Physician or Duly Authorized Representative Signature Jennifer Gentry Calvo, NMD	(Date)		Patient's Signature	(Date)
By:	ommer outry during many		By:		
	Print or Stamp Name of Physician, Medical Group or Association Name			Print Patient's Name	
By:			By:		
	Signature of Translator (if applicable)	(Date)		Patient's Representative's Signature	(Date)
	Print Name of Translator			Print Name and Relationship to Patien	nt

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.